



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

BAYLOR SURGICARE CENTER AT PLANO

Respondent Name

BERKLEY REGIONAL INS CO

MFDR Tracking Number

M4-16-3668-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

AUGUST 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2016 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: \$1,431.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOB(s) and the reduction rationale(s) stated therein."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 2016	Ambulatory Surgical Care for HCPCS Code L8699 plus Interest	\$1,431.49	\$3,036.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. Texas Labor Code 413.011(b) provides for additions or exceptions to the Medicare policies.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment code:
 - 16-Claim/service lacks information which is needed for adjudication. Remark codes whenever appropriate.

Issues

1. Does the documentation support billing HCPCS code L8699?
2. Is the requestor entitled to reimbursement for HCPCS code L8699?

Findings

1. On the disputed date of service, the requestor billed CPT codes 29806, 29826, 29824 and L8699 provided in an Ambulatory Surgical Care Center. The requestor is only seeking dispute resolution for code L8699.

HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified."

According to the submitted explanation of benefits, the respondent denied reimbursement for HCPCS code L8699 based upon "16-Claim/service lacks information which is needed for adjudication. Remark codes whenever appropriate."

A review of the submitted Operative and Implant Record reports find six Suture Anchor, BioComposite Push Lock implants were used during the procedure. In addition, the requestor submitted an Arthrex Invoice to support the cost for the Suture Anchor, BioComposite Push Lock implant. Based upon this information, the Division finds the respondent did not support the denial of reimbursement based upon reason code "16"; therefore, the requestor is due reimbursement.

2. 28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii) states

The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent.

The Division reviewed the submitted medical bill and finds that the requestor did request separate reimbursement for the implantables on box 19; therefore, the disputed services were applicable to the reimbursement methodology outlined in 28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii).

28 Texas Administrative Code §134.402(d) states

For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

Section 413.011(b) of the Texas Labor Code states

In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d). The commissioner shall also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c) and commissioner rules. This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services.

28 Texas Administrative Code §134.402's preamble states

The Division is adopting minimal modifications to Medicare's reimbursement methodology to reflect use of separate reimbursement for surgically implanted devices in non-device intensive

procedures to ensure injured employees have access to care, including surgery where surgically implanted devices are medically necessary.

According to *Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2016* (Including Ancillary Services for Which Payment is Packaged), HCPCS Code L8699 has a payment indicator of "N1".

Addendum DD1, Final ASC Payment Indicators for CY 2016, defines payment indicator "N1" as "Packaged service/item; no separate payment made."

Section 413.011(b) of the Texas Labor Code, 28 Texas Administrative Code §134.402(d) and its preamble, provide for the exception to Medicare's policies and allow separate reimbursement for implantables in non-device intensive procedures.

Per the submitted invoice, the cost of Suture Achor, BioComposite Push Lock implant is \$460.00 each.

Per 28 Texas Administrative Code §134.402(f)(1)(B)(i) the total due for implantables is $\$460.00 \times 6 \times 10\% = \$3,036.00$. The respondent paid \$0.00. Per the *Table of Disputed Services*, the requestor is seeking dispute resolution for \$1,085.24 for code L8699.

28 Texas Administrative Code §134.402(e)(2) states

Regardless of billed amount, reimbursement shall be: if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any reimbursement for implantables." A review of the submitted documentation finds that the disputed services are not subject to a contracted fee schedule; therefore, reimbursement is per the MAR.

Per 28 Texas Administrative Code §134.402(e)(2) the requestor is due \$3,036.00 for code L8699.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$3,036.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$3,036.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	9/13/16
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.